

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? () Yes (x) No
Requestor's Name and Address Dr. S, MD 431 Omega Drive, Suite 104 Arlington, Texas 76014	MDR Tracking No.: M4-03-7179-01
	TWCC No.: _____
	Injured Employee's Name: _____
Respondent's Name and Address Texas Mutual Insurance Company Box 54	Date of Injury: _____
	Employer's Name: _____
	Insurance Carrier's No.: 99A0000244599

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/03/03	01/03/03	99214	\$71.00	\$71.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in their position statement, "We contend that the documentation clearly supports the level billed."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response was untimely. Carrier's EOB denial is "Documentation does not support the level of service billed. Carriers may not reimburse the service at another billing codes' value per rule 133.301(B). A revised CPT code or documentation to support the service billed may be submitted."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Documentation submitted by the requestor meets the criteria per rule 133.1 (E)(i). The documentation contains at least two of the three components required per the above mentioned rule.

Therefore, based on this information reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement in the amount of **\$71.00**. The Division hereby ORDERS the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of the Order.

Ordered by:

Michael Bucklin

12/27/04

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____